Request for Qualifications
Social, Emotional, Behavioral and Family Support

ATTACHMENT 1: COVER SHEET

Applicant Information:

Applicant name: Therapeutic Health Services

Applicant address: 1116 Summit Avenue, Seattle, WA 98101

If applicable, Web address: www.ths-wa.org

Contact Information:

Contact person: Ken Schlegel
(please print clearly)

Title: Director of Development & Marketing

Mailing address: 1116 Summit Avenue, Seattle, WA 98101

Day/Work phone: (206) 323-0930 x. 201 Email address: kenneths@ths-wa.org

Signature: Kenneth Schlegel Date: 10.18.2012.

Describe your legal status and, if applicable, state of incorporation (for example, Washington State non-profit corporation, Washington State partnership, sole proprietorship:

Washington State non-profit corporation

Application Components and Checklist (submit in this order)

- ☐ **Cover Sheet**
- ☐ **Key People**
- ☐ **Previous Experience Improving Student Outcomes**
- ☐ **Tracking to Success**
  - **Attachment 2: Data Sample(s)**: *If separate from the RFQ document, please use this naming convention:*

    [Applicant Name]_SEBFS_DataSample

    Example: IZAFamilyServices_SEBFS_DataSample
- ☐ **Women and Minority Inclusion; Non-discrimination**

Section 1: Key People

1) The person who will lead the project to its results is Anthony Austin, M.Ed., Clinical Supervisor. He has 8 years experience working with elementary, middle and high school age students and their families, including parent training groups, case management, assessment, and crisis intervention. Since 2010, he has supervised clinical staff members stationed on-site at Madrona K-8 School. These staff members provide assessment, support, intervention and individual and group counseling to elementary and middle school students. Anthony manages and monitors contract outcomes and requirements and helps develop and implement program curricula. During the 2011-2012 school year, he oversaw a program that provided services to nearly 75% of the student body each month and more intensive support to nearly 30% of students. Of these students, 65% showed improvement in their grades and 75% showed improved behavior and decreased discipline issues. For the current school year, 65% of students who received intensive services in 2011 have zero absences, 35% have only one absence, and 65% are passing all of their classes.

2) The key staff people who will deliver the proposed services are Julie Olsen, MA and Carlton Buren, CDPT. Julie has 8 years experience working with youth with behavioral/emotional issues and their families both in a school-based educational setting and at home. She also has extensive experience working with the parents of students to help implement effective parenting skills. She currently provides assessment, support, intervention and individual and group counseling (e.g. anger management, grief and loss, drug & alcohol education, etc.) to middle school students and their families at Madrona K-8. Carlton is a Chemical Dependency Professional Trainee with training and experience in evidence-based practices including Motivational Interviewing, GAIN-SS, GAIN-I, ACRA and Seven Challenges. He currently is attending training in Dialectical Behavioral Therapy. He has worked with Seattle Public Schools' Interagency Academy for over three years providing assessments, individual and group counseling, intervention outreach and case management services. He has 4 years experience working with at-risk youth through direct service (outpatient treatment, case management, outreach, etc.) and 2,500 hours of experience in Chemical Dependency treatment services.

Section 2: Previous Experience Improving Student Outcomes

1) THS has extensive experience providing services to the target population. Founded in 1972, for 40 years we have provided integrated, culturally-relevant mental health and chemical dependency services for adults and their families. In 2006, we expanded our ability to serve at-risk youth through a merger with Central Youth & Family Services, a non-profit with 25 years experience service at-risk, low-income youth in Seattle and King County. Today, our 9 branches offer a full range of treatment services for families affected by substance abuse & mental illness. Our services are accessible to youth regardless of geography, ethnicity, class, gender, income, education, sexual orientation, age, ability or language, though we have a special emphasis on high-risk, low-income, ethnic minority (90% are from racially diverse backgrounds, 91% are from low-income families), multi-system involved, "harder to serve" youth and their families who have had multiple treatment failures, and are located in Seattle's highest gang/youth violence problem areas – Seattle's Central District, South Seattle, and SW Seattle. More than 50% of our clients have some involvement with corrections or the juvenile justice system. Many are in the foster care system or have "aged out" and are now

homeless; about 65% have no health insurance. We are the primary provider of chemical dependency treatment services in WA State for African American youth, and we are designated by the State as the consulting mental health agency for Afri-ethnic mental health issues.

Common presenting issues for our youth clients include:

- School problems (e.g., truancy, poor grades, attendance, disciplinary issues)
- Depression
- Behavioral/anger management issues
- Cultural identity/acculturation issues
- Lack of parenting/ parental monitoring
- Trauma/post-traumatic stress
- Anxiety
- Gang involvement/violence
- Grief/loss
- Family conflict
- Sexual/physical abuse
- Suicidal ideation/self-harm
- Poor social skills/peer relationships
- Lack of basic needs/ homelessness
- Substance use/abuse
- Criminal behavior

Because of our comprehensive, integrated programs, we have a long history of serving children or youth who are multiple-system involved (mental health, substance abuse, child welfare, juvenile justice, foster care, developmental disabilities, or special education programs). We have extensive experience working with students who have barriers to learning such as emotional or chemical dependency issues that lead to poor school performance (grades or state assessments) or truancy. Each year we provide services to more than 9,500 individuals and families, including over 1,700 youth and young adults.

We have a long record of school-based collaborations. We provide case management, mental health and chemical dependency intervention, treatment, prevention, individual and group counseling, advocacy, referral, and outreach services to at-risk students in 51 King County area elementary, middle and high schools, 40 of which are in the Seattle School District. Currently, the majority of referrals to our youth programs come from these schools. We collaborate and maintain effective relationships with school personnel (e.g., counselors, principals, administrators, teachers, intervention specialists, volunteer coordinators, and school security) to ensure access to youth where they spend most of their day. This also provides us with ongoing relationships with school staff so that when at-risk youth are identified, referrals to services are seamless and school staff may be part of the youth's treatment team.

We also collaborate with the Seattle Public Schools Office of Discipline and Truancy and School Safety Net Program to provide behavior modification counseling to referred students following a suspension or other disciplinary action requiring re-entry services. We also provide school-based crisis intervention, violence prevention, intervention, and counseling services for victims as well as perpetrators of violence throughout the Seattle Public Schools system. We manage the Central Area Network of the Seattle Youth Violence Prevention Initiative. We have also been called upon by the Seattle Public School District to provide on-site critical response and grief and loss counseling due to acts of violence affecting students at Garfield, Franklin, and Cleveland High Schools.

2.) Some of the challenges and barriers that our intended students face include gang involvement, violence, multi-system involvement (CPS, juvenile court, special education, etc.), lack of family involvement, poverty, lack of stable housing, lack of adequate health care,

mental illness and/or drug and alcohol use or dependence. All of these factors have been shown to reduce school performance, attendance and graduation rates. There also appears to be an increase of children, youth and their families that have been affected by trauma as a result of violence in the community, as evidenced by an increase in the request for services by the community.

We address these issues by working with a number of Seattle Schools to provide assessment, crisis intervention, case management services, parenting classes, and individual and group counseling. We provide services in community-based locations where appropriate and we cultivate and hire staff members who reflect our client population. Our strategy to engage multi-ethnic communities in high gang and youth violence problem areas has been to establish effective partnerships with other community-based youth and family service organizations and to host culturally relevant events (e.g., Juneteenth Barbecue, Black History Celebration). We maintain a culturally relevant, strengths-based approach that incorporates family traditions, values, and heritage with other, more formal treatment activities. For example, we use the Strengthening Multi-Ethnic Families & Communities program, with materials available in many languages, which targets ethnic/culturally diverse parents who want to raise their children to lead a violence-free, healthy lifestyle. It provides a unique integration of prevention/intervention strategies to reduce violence against self, the family, and the community; and reduce drug/alcohol use, teen suicide, juvenile delinquency, gang involvement, child abuse, and domestic violence. In addition, when connecting youth and their families with outside resources or natural supports, we seek out places and people that share the same individual/family values and cultural identity. We are committed to an individualized, creative approach to working with diverse youth. We engage youth in programs that pique their interest, focus on their assets, provide consistency, build trust, and help them begin to deal with issues underlying their problem behaviors. Our services are driven by identified client/family need, cultural relevance, practical knowledge/experience of “what works,” and clinical research.

We provide crisis intervention, violence prevention, intervention, and counseling for victims as well as perpetrators of violence. When youth have been shot in Seattle over the last few years, THS staff have been in direct contact with these youth and their families and were integral to preventing further retaliation. We also play an active role in addressing youth violence through participating in community events. For example, in Dec. 2008, after youth gang shootings in Seattle, we organized a peace rally attended by more than 50 youth, family, and community members; at this rally THS was charged with the call to offer continued/enhanced services for at-risk youth.

3.) During the year ending 6/30/2012 across all youth programs, 92% of our youth and young adults with emotional and behavioral disturbances developed/strengthened their coping skills, we had 97% success for youth developing skills and competencies that support positive development and 52% success for youth following through with treatment; abstaining from or reducing drug use and making progress in addressing other issues impacted by alcohol/drug dependency.

In our Madrona K-8 school-based program, during the 2011-2012 school year we provided services to nearly 75% of the student body each month and more intensive support to nearly 30% of students. Of these students, 65% showed improvement in their grades and 75% showed improved behavior and decreased discipline issues. For the current school year, 65% of students who received intensive services in 2011 have zero absences, 35% have only one absence, and 65% are passing all of their classes. We work closely with school staff to obtain

relevant data such as grades and attendance records and attend weekly meetings with staff to discuss program implementation and student needs.

We have a contract with the City of Seattle to provide mental health counseling for youth. Under this contract, in 2011 we served 36 elementary-aged youth. In accordance with our contractual responsibilities, we track a number of indicators and outcomes depending on the client's needs and treatment plan. In 2011, 52% of our elementary-age clients who had the indicator tracked met the indicator for improved communication with family members and 40% showed some positive change. 37.5% met the indicator for increased family involvement with the school and 50% showed some positive change. 38.5% of our clients met the indicator for increased school enrollment and attendance and 30.8% showed some positive change. 50% met the indicator for reduction in school disciplinary actions and 25% showed some positive change. 50% had a reduction in antisocial behavior, 40% showed some positive change, and 10% had a decrease in functioning. 50% had a reduction in involvement with the juvenile justice system or increased compliance with juvenile justice, 33.3% had some positive change and 16.7% showed no change. 48% met the indicator for improvements in mood and 40% had some positive change. 42.9% of our students met the indicator for reductions in oppositional behavior, 28.6% showed some positive change and 14.3% had a decrease in functioning. 25% met the indicator for meeting basic needs, 37.5% had some positive change and 25% showed a decrease in functioning.

Section 3: Tracking to Success

1.) The data points that we track for each client vary depending on the individual treatment goals. Across all of our programs, our outcome indicators include: reduction in antisocial behaviors, reduced mental health/psychiatric symptoms, progress on treatment plan goals, number school absences, participation (i.e. completing homework, class participation), grades (GPA), school disciplinary reports, decision-making and coping skills, treatment completion, drug/alcohol use, involvement in the criminal justice system, and family involvement.

2.) Our comprehensive practice management system supports Electronic Medical Records and a wide range of data reporting capabilities including client demographic data, clinical documentation including assessments, service and progress note data, treatment plans, and progress towards meeting outcomes. Our Data Department is proficient in custom programming that supports our ability to tailor our EMRs to produce reports and data collection forms that effectively satisfy the requirements of our contracts and evaluation priorities. In addition to subjective measures of progress (e.g., self-report, counselor report), we work with school staff to collect more objective/corroborating information such as attendance records, grade reports, urinalysis results, and teacher and parental feedback. In addition to internal agency measures, we utilize external outcome data such as DASA Treatment Analyzer and TARGET outcome data to inform our evaluation process.

We collect participant satisfaction data regularly (at intake, during treatment, and at discharge) to evaluate our services and informing us in areas where we can improve.

3.) We consistently use data to inform our treatment plans. We review student progress toward goals every 90-days, but use attendance reports, grades, urinalysis, and parent or teacher reports to modify our treatment as necessary. These objective measures allow us to identify problems early and address them in treatment. For example, if we receive a report from a school that a client is skipping school, we will address this issue in treatment sessions. In addition, if we see a problematic trend, we can identify it early and address it in sessions.

We receive reports weekly from Madrona K-8 and Interagency Academy. These reports include attendance, behavioral issues (for example, marijuana use on campus or expulsions),

and treatment compliance. We also receive reports for our other clients on an as-needed basis. The school will contact us if there is an issue relating to one of our clients. We utilize these reports in our treatment sessions to tailor treatment to identified issues.

4.) We have provided intensive services at Madrona K-8 for over 4 years, and it became clear that while we were having a positive impact on students during the school year, progress became stalled during the summer months. As a result, in 2012 we implemented the Madrona Summer Enrichment Academy (MSEA). Of the 23 students enrolled in the program, 80% showed improved behaviors during the program. For the initial months of the 2012-2013 school year, 65% of those students have had zero absences, 35% have had only one absence and 65% are passing all of their classes.

In our ENCOMPASS™ program for youth with co-occurring mental health and substance abuse disorders, we found that 40% of our clients had nicotine dependence. While they were making progress in addressing their mental illnesses and drug/alcohol dependence, their nicotine use either stayed the same or slightly increased. It was clear that unless nicotine use is specifically addressed in treatment sessions, there will not be a change in use patterns. As a result, in 2012 we modified the ENCOMPASS™ curriculum to include addressing nicotine use. Early results suggest that nicotine use is decreasing among program participants.

Section 4: Women and Minority Inclusion; Non-discrimination

We do not anticipate subcontracting or hiring additional employees.

SAMPLE DATA REPORT

OUTCOMES/INDICATORS

FF-1 Improve communication with family members
FF-2 Out of home placement or runaway
FF-3 Family involvement/connection with school
AA-1 School Enrollment/Attendance
AA-2 Grades
AA-3 Credits on target for graduation
AA-4 Promotion to next grade level
AA-5 Successful transition from Middlle to High School
AA-6 Post high school plans
AA-7 Disciplinary actions
AA-9 Meeting graduation requirements

PR-1Physcial Altercations
PR-2 High-risk behaviors (sex, breaks curfew, etc)
PR-3 Gang Involvement
PR-4 Anti-social behavior
CAI-1 Lack of pro-social, culturally relevant
CAI-2Lack of adult role models non family members
CAi-3 Juvenile justice involvement
IEBH-1 Mood
IBEH-2 Anxiety
IBEH-3 Oppositional behavior
IBEH-4 Drug/Alcohol Use
IBEH-5 Eating Disorders
IBEH-6 Self Harm Behaviors

SR-1 Basic Needs
SR-3 Language
SR-5 Isolation
SR-6 Rival Gang Presence
SR-8 Learning Disability
SR-9 Self Safety of School
SR-10Safety of route to school
SR-11 Lack of Monitoring
SR-12 Lack of Parent support
SR-13 Appropriate Placement

Client # 74545

Date: 2/14/12

Family Communication-Involvement	FF-1	Some positive change
	FF-3	No change
School Participation	AA-1	Met Outcome
	AA-3	Some positive change
	AA-2	Met Outcome
Peer Relations	PR-4	Met Outcome
	PR-3	Some positive change
Community Functioning	CAI-2	Some positive change
	CAI-3	Met Outcome
Individual Functioning	IBEH-3	Met Outcome
	IEBH-1	Met Outcome
School Readiness	SR-12	Some positive change
	SR-1	Met Outcome

Client # 42658 Date: 2/14/12

Family Communication-Involvement	FF-2	Some positive
	FF-1	No change
School Participation	AA-1	Met Outcome
	AA-4	Met Outcome
	AA-7	Some positive change
Peer Relations	PR-4	Met Outcome
	PR-3	No change
Community Functioning	CAI-2	Some positive
	CAI-3	Met Outcome
Individual Functioning	IBEH-3	Met Outcome
	IEBH-1	Met Outcome
School Readiness	SR-8	Some positive
	SR-1	Met Outcome